



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MMC OF EAST TEXAS
1201 LAKE WOODLANDS DRIVE SUITE 4024
THE WOODLANDS TX 77380

Respondent Name

Texas A & M University System

Carrier's Austin Representative Box

Box Number 29

MFDR Tracking Number

M4-12-1299-01

MFDR Date Received

December 28, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier's denial is demonstrably false."

Amount in Dispute: \$82.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Starr Comprehensive Solutions, Inc. maintains its position that the radiographic examination exceeded the ODG in this case, therefore, preauthorization was required in accordance with DWC rule 134.600(p)(12)."

Response Submitted by: Starr Comprehensive Solutions, Inc P.O. Box 801464, Houston, TX 77280

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
March 29, 2011	Outpatient Hospital Services	\$82.24	\$43.38

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines an emergency.
3. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated May 15, 2011

- W1 – Workers Compensation State Fee Schedule Adjustment
- 97 – Payment is included in the allowance for another service/procedure
- 150 – Payment adjusted because the payer deems the information submitted does not support this level of

service

- 197 – Payment denied/reduced for absence of precertification/authorization

Explanation of benefits dated July 6, 2011

- W1 – Workers Compensation State Fee Schedule Adjustment
- 97 – Payment is included in the allowance for another service/procedure
- 197 – Payment denied/reduced for absence of precertification/authorization
- 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with reason code, 197 – “Payment denied/reduced for absence of precertification/authorization” and Comments - 197 – “Per rule 134.600(p)(12), Non-emergency health care requiring preauthorization includes treatments and services that exceed or are not addressed by the Commissioner’s adopted treatment guidelines or protocols.” 28 Texas Administrative Code §133.2(4)(A) states that, “a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient’s health or bodily function in serious jeopardy, or (ii) serious dysfunction of any body organ or part.” The medical documentation meets the definition of an emergency pursuant to §133.2(4)(A). For example:
 - a. Nursing record shows patient stated pain level to be 10/10.
 - b. Emergency Physician Record shows patient has “severe pain” and “sudden onset of rt shoulder pain.”

The Division concludes the denial code 197 is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 73030 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$45.04. This amount multiplied by 60% yields an unadjusted labor-related amount of \$27.02. This amount multiplied by the annual wage index for this facility of 0.8549 yields an adjusted labor-related amount of \$23.10. The non-labor related portion is 40% of the APC rate or \$18.02. The sum of the labor and non-labor related amounts is \$41.12. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$41.12. This amount multiplied by 200% yields a MAR of \$82.24.
 - Procedure code 99284 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. This line is assigned status indicator V, which denotes a

clinic or emergency department visit paid under OPSS with separate APC payment. These services are classified under APC 0615, which, per OPSS Addendum A, has a payment rate of \$222.58. This amount multiplied by 60% yields an unadjusted labor-related amount of \$133.55. This amount multiplied by the annual wage index for this facility of 0.8549 yields an adjusted labor-related amount of \$114.17. The non-labor related portion is 40% of the APC rate or \$89.03. The sum of the labor and non-labor related amounts is \$203.20. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$203.20. This amount multiplied by 200% yields a MAR of \$406.40.

- Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code 96372 is unbundled. This procedure is a component service of procedure code 99284 performed on the same date. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
4. The total allowable reimbursement for the services in dispute is \$488.64. This amount less the amount previously paid by the insurance carrier of \$445.26 leaves an amount due to the requestor of \$43.38. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$43.38.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$43.38, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

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Signature	Medical Fee Dispute Resolution Officer	May 3, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a *certificate of service* demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.